Editorials

There's a Long, Long Trail A-winding . . .

WOMEN HAVE BROUGHT special skills, outlooks, and, yes, intuition to the medical profession and have enriched it. We have been sought out by many patients, welcomed by others, and at least tolerated by the remainder. We have been graced by mentors and colleagues who live by fairness and honor talent where they find it.

The first woman physician trained in the United States, Elizabeth Blackwell, was admitted to Geneva Medical College in 1847, despite opposition from the faculty, who delegated the decision to her rowdy prospective classmates. The class voted unanimously in her favor after the one "nay" voter was beaten into submission. Her attendance at classes brought order to chaos despite the tumultuous admissions process. "The sudden transformation of this class from a band of lawless desperadoes to gentlemen, by the mere presence of a lady, proved to be permanent in its effect."[1(pp65-66)] It seemed a promising beginning, but the path ahead was to be marked by controversy, restrictions, and unpleasant incidents. Indeed, Elizabeth Blackwell's own sister was denied admission to Geneva despite Elizabeth's fine record because the faculty did not wish to set a precedent. In 1850, the Harvard Medical School admitted a woman student, along with three African Americans, but all were forced to withdraw after student riots; women were not admitted to Harvard again until 1945. In 1919, when the distinguished occupational medicine specialist, Alice Hamilton, became the first woman physician faculty member at the Harvard Medical School, conditions were attached that seem almost unbelievable. This woman, adjudged to be sufficiently outstanding to be given a faculty appointment, could not join in academic processions; could not be a member of the faculty club; could not exercise the faculty option for season football tickets!

It has not been an easy road. Women physicians have endured comments, jokes, prods, and worse. Some have been passed over, ignored, dismissed. My internship in the 1960s was marred when I was slapped in the face by a professor because I could not answer his question. I did not report the incident. It didn't occur to me to do so. Even today, as women contend with covert or overt discrimination, most do not or cannot speak out.

Data continue to confirm women's slower promotion in academic faculty ranks compared to men.[2] Although women physicians work 8% fewer hours per week than men, women earn about 40% less than men.[3] Leaders inside and outside medical schools have been slow or unwilling to set standards to make sexist barbs and practices wholly unacceptable. Professional organizations seem to have an overweening pride about the rather few women who belong and the very few who lead.

How have women physicians weathered tough times and unfairness? We have had support from family, friends, faculty, and colleagues. We haven't complained much. Complaining wouldn't be seemly; it would also be a career-limiting activity. We have worked extraordinarily hard, have deliberately chosen specialty roads less travelled or more predictable in order to avoid competition or haphazard schedules. We have tempered professional ambitions and personal hopes in order to meet expectations of others. We have learned to be highly organized coordinators and jugglers, even jesters. A sense of humor can wear thin, however.

All physicians need to press on with resolve. We should attend to language, to words. Thoughtless words can degrade. Instead, words should encourage and show respect. But good words are only a start. We also must act. Action should promote progress. Doors must be opened and runways cleared. Women physicians have come far—and have a long way to go. The way can be smoothed by men and women with spirit, with the will to move ahead.

LINDA HAWES CLEVER, MD

REFERENCES

1. Blackwell E: Pioneer Work in Opening the Medical Profession to Women. London, Longmans, Green, 1895

2. Bickel J: Women in medical education. N Engl J Med 1988; 319:1579-1584

3. American Medical Association Center for Health Policy Research: Income comparisons of male and female physicians. SMS [Socioeconomic Monitoring System] Report 1989; 3:3-4

Physicians and the Human Immunodeficiency Virus

THE MAGNIFYING GLASS of the acquired immunodeficiency syndrome (AIDS) epidemic has increasingly become a looking glass as well, reflecting physicians' attitudes and behaviors and society's reaction to them. The image we see, particularly regarding those physicians who are infected with the human immunodeficiency virus (HIV), is neither clear nor necessarily encouraging. Yet some clarity is urgently needed—some physicians *are* HIV infected, others will become infected, and as they become aware of their infection, it seems unfair not to provide some clear standards of behavior if they wish to continue and are otherwise capable of continuing to practice their profession. The unacceptable alternative is to let the appropriateness of each infected physician's response be judged by the public through the news media as the disease progresses to the point where confidentiality is no longer possible. It is hoped that a better understanding of the individual components of this social equation might enable the medical profession to instead play an active and leading role in proposing solutions that are fair to affected physicians and reassuring to patients.

Many physicians see themselves as selfless and devoted through their profession to the care of others. Limitations to this self-view became obvious, however, as soon as the infectious nature of AIDS was clear. Each of us feared for our safety, and some physicians—overtly in some cases, covertly in others—found ways to avoid caring for AIDS patients, even if the resulting quality of delivered medical care suffered. To justify these ignoble actions, some physicians have publicly exaggerated the risks posed by caring for HIV-infected patients. Some of the embellishment has been due to fear, some due to homophobia. There has also been the implication that physicians (usually internists) who do not join in these claims are unsympathetic to their surgical colleagues. Worse is the implication that physicians caring for HIV-infected patients are under the influence of the gay community. The argument goes that the gay community is more concerned about receiving confidential medical care than it is about the risk its members might pose to physicians. These

arguments begin to split physicians from patients and from each other.

Recognizing and correcting homophobia may be difficult for many, but insisting on actual data regarding transmission risk should be easier. Here, with respect to the risk of physicians acquiring HIV from patients, the data have been increasingly reassuring. Even orthopedic surgeons, argued by some to be at a theoretically high occupational risk, have been shown to be free of HIV unless they have had nonoccupational transmission-prone behaviors. The *documented* degree of risk, as opposed to the *speculated* risk, is insufficient as the basis for compromises in patient confidentiality or limitations in access to optimal medical or surgical care. Similarly, evidence of any benefit to physicians from routine nonvoluntary testing and reporting of patients for HIV is also lacking.

Now that data show the limited risk of transmitting HIV from patients to professionals, the number of calls for involuntary HIV testing and reporting of patients has decreased. Our current situation with HIV-infected physicians appears at first to be very different. The transmission of HIV to patients in the office of an infected dentist is recognized to have occurred. Instead of physicians being afraid, patients are now afraid. Instead of patients putting physicians at risk because of their socially disapproved behaviors, medical professionals are portrayed as irresponsible and selfish and willing to put their patients in jeopardy to protect their own privacy and careers. If opinion polls are to be believed, 90% of all adult Americans believe that something needs to be done to protect them from their physicians. In a rapid response, especially following the publication of these opinion polls, draconian (Helmsian) bills criminalizing the practice of medicine have passed the US Senate, and even the most moderate positions taken by the Centers for Disease Control, the American Medical Association, and the Senate "leadership" bill would probably eventuate in mandatory physician HIV testing, at least in some states, and an essentially forced termination of practice. How confident are we that when left to local specialty boards, "exposure-prone procedures" will not include essentially all surgery? Recall the Chicago physician with HIV for whom "invasive" procedures included routine oral examination with an instrument no sharper than a tongue depressor.

Is all of this necessary? Will we look back at these measures as appropriate and useful in instilling public confidence in the medical profession? Or will we see it as an overreaction that perpetuates the fractures of the medical communities and abdicates responsibility for the profession and for public health in favor of momentarily popular and political forces? Certainly our past experience with physicians' fears of patients might have taught that data can be reassuring, not just alarming, and that initial reactions in the absence of data might be based more on fear and discrimination.

Given that, what is the strength of the current data on the risk physicians might pose to patients? Five patients were infected in one dentist's office, but not one of the hundreds of other patients of HIV-infected surgeons who have been "recalled" for testing are reported to have acquired HIV. Many physicians, on receiving an HIV-positive report, immediately ask themselves whether they should alter their practice. Some have done so, whereas others—again after careful consideration and consultation with AIDS experts—decide to continue their careers, believing that the care they provide outweighs the remote risk of transmission. Some of these conscientious physicians nevertheless live in mortal fear that they will be publicly exposed, humiliated, and ruined.

Most American adults may be afraid, but perhaps they are also wrong. Knowing how little data are now available, we can at least assume that public opinion is not fully informed. We might also believe that it recognizes neither the potential harm in taking the wrong steps at this time nor that other approaches are possible. The media will forget about HIV-infected physicians, as they have forgotten about other health-related issues after an amazingly short period. With more time and data, public opinion will also change rapidly. Most physicians will continue to act in their patients' and their own best interests. Physicians will be voluntarily tested for HIV in confidential settings, and they will use this information to adjust their practices if they think they pose any risk to their patients.

Meanwhile, the medical profession must stop reacting to uninformed political pressure and insist that it can and must deal with this issue itself. As voluntary guidelines are established, physicians can vigorously and quickly collect additional information. They can develop a consensus about the degree of risk that can be tolerated, as is done for other common conditions that might impair a physician's performance and hence patients' safety. In a sense, the difficulties of charting a course on the current debate and the scrutiny physicians are under offer unique opportunities. If the medical profession succeeds in creating an informed public and political opinion and if rational policies result from this, at least some pride in its leadership could be restored. Also, if it is insisted that standards of safe physician behavior be developed beyond those that simply address HIV, the overall quality of medical care can benefit from these efforts.

PAUL A. VOLBERDING, MD
Professor of Medicine
University of California, San Francisco, School of Medicine
Director, AIDS Program
San Francisco General Hospital Medical Center
San Francisco, California

Liver Transplantation—Challenges for the Future

ORTHOTOPIC LIVER transplantation (OLT) is the accepted treatment of a variety of irreversible acute and chronic liver diseases for which no other form of therapy is available.[1-3] Liver transplantation was initiated nearly 30 years ago when the first human OLT was performed by Starzl in 1963; survival for more than a year was not achieved until 1967, however. The one-year survival rate following OLT was approximately 30% before 1980 but increased to 65% in the early 1980s at the University of Pittsburgh (Pennsylvania).[1] These improved results led a consensus development conference of the National Institutes of Health to conclude in June 1983 that liver transplantation was no longer experimental.[4] This conference was instrumental in broadening funding for the procedure by health insurance carriers and government agencies and in stimulating the development of more transplant centers, resulting in the increased availability and performance of liver transplantation.[5] In 1989, a total of 2,162 liver transplantations were done at 69 transplant centers in the United States; in 1990, there were 2,656 liver transplants performed, a 23% increase over the previous year. In 1989, about 60% of liver transplant procedures in the United States